



# Perinatal Depression:

## A Massachusetts Department of Public Health White Paper

### 1. BACKGROUND

#### Perinatal Depression

- **Definition: “Perinatal”** means anything pertaining to pregnancy or postpartum up to a year after giving birth.<sup>1</sup> Also known as Maternal Depression. Perinatal depression is a multifaceted illness that describes a range of physical and emotional changes that many mothers can have during pregnancy or after giving birth. The condition has varying consequences for a woman’s mental health, her functioning as a mother, the family’s functioning, and her child’s development.<sup>2</sup>
- **What does perinatal depression look like?**

#### **General Signs And Symptoms:**

- ✓ Feeling restless
- ✓ Increased crying/crying often
- ✓ Lack of energy
- ✓ Feeling anxious, jumpy or irritable
- ✓ Sleeping too much or not sleeping enough
- ✓ Eating too much or not eating enough
- ✓ Having headaches or chest pains
- ✓ Loss of interest in family
- ✓ Loss of interest in your usual fun activities
- ✓ Feeling guilt
- ✓ Feeling despair
- ✓ Afraid of hurting yourself or your child

#### **Terminology:**

- ✓ **Prenatal depression:** Prenatal depression occurs during pregnancy when mothers-to-be experience hormonal and biological changes, stress, and the demands of pregnancy. Early identification is essential- 50% of all women who experience prenatal depression also develop postpartum depression.
- ✓ **Postpartum blues:** Postpartum blues are considered “normal” since they are so commonly experienced worldwide. The blues are experienced by 50 to 80% of all mothers within the first 10 days after childbirth. Symptoms are usually mild and do not interfere with mother’s caring for her infant.
- ✓ **Postpartum depression:** Postpartum depression is a clinically significant condition and requires serious medical attention from a health care provider. This condition is manifested in major depressive episodes lasting two weeks or more and may last for a period of weeks or for longer than a year
- ✓ **Postpartum psychosis:** Postpartum psychosis is the most severe of conditions related to maternal depression, with symptoms ranging from hallucinations and paranoia to suicide or infanticide. It is handled as a psychiatric emergency.

**\*Suggested Reading for detailed descriptions:**

Onunaku N. *Improving Maternal and Infant Mental Health: Focus on Maternal Depression*. Los Angeles, CA: National Center for Infant and Early Childhood Health Policy at UCLA; 2005.

Sichel, D. & Driscoll, J. W. (1999). *Women's moods: what every woman must know about hormones, the brain, and emotional health*. Morrow/Avon: New York, NY.

- **Contributing factors:** Factors that can place mothers at risk for maternal depression include prior history of depression, family history of depression, hormonal changes experienced during pregnancy, genetics, domestic violence, poor environment (e.g., food insecurity, poor housing conditions, lack of financial supports, uninvolved husband or partner), and the absence of a community network.<sup>3</sup>
- **National prevalence:** 10% to 15% of women suffer from depression during pregnancy. A recent study found that 1 out of 7 women suffer from depression during or after pregnancy.<sup>4</sup>
- **MA prevalence:** The Pregnancy Risk Assessment Monitoring System (PRAMS) survey of Massachusetts women who gave birth in 2007 found that of women surveyed:
  - ✓ 31% reported that they often or sometimes felt down, depressed or hopeless since their new baby was born.
  - ✓ 29% reported that they often or sometimes had little interest or little pleasure in doing things since their new baby was born.
  - ✓ 20% of these women sought help.<sup>5</sup>

### **Impact On Infant Development**

- Babies depend on the emotional nurturance, protection, and stimulation that depressed mothers may not consistently provide. Infants of clinically depressed mothers often withdraw from daily activities and avoid interactions, have a hard time attaching to their caregivers, and experience higher stress levels. In turn this jeopardizes infant language, physical, intellectual, and emotional development.
- Older children of mothers depressed during infancy often exhibit poor self-control, aggression, poor peer relationships, and difficulty in school, increasing the likelihood of special education assignment, grade retention, and school dropout.

For more information please see supplemental “impact on infant development” sheet as well as following resource:

- Weinberg, Katherine, and Edward Tronick. “*The impact of maternal psychiatric illness on infant development.*” Child Development Unit, Children's Hospital, Boston Mass 02215, USA
- Weinberg, Katherine, and Edward Tronick. “*Emotional Characteristics of Infants Associated With Maternal Depression and Anxiety.*” PEDIATRICS Vol. 102 No. 5 Supplement November 1998, pp. 1298-1304

## **2. MATERNAL AND INFANT MENTAL HEALTH PROJECT**

- The Maternal and Infant Mental Health Project (MIMHP) is two year project supported by a federal grant from HRSA's Maternal and Child Health Bureau. The Project is a collaborative effort of community organizations, state departments and agencies, and experts in the field of maternal mental health and infant mental health.
- **Goal:** Improve maternal well being and infant mental health through early detection, prevention, and treatment focusing on the **mother-infant dyad**.
- The Project has implemented interventions on three levels:
  - ✓ **Individual level:** The Project has developed interventions focused on identifying and providing mother-infant dyad services for women and infants experiencing, or at risk for mental health issues.
  - ✓ **Social level:** The Project has worked to increase community and social support for pregnant and parenting women and their infants
  - ✓ **Organizational level:** The Project has worked to enhance the capacity of community and state partners to support positive mental health for care givers and their infants.

## **3. SUCCESSFUL MIMH PROJECT STRATEGIES FOR ADDRESSING PERINATAL DEPRESSION**

### **Strategy One: Home And Group-Based Services**

- The Project collaborated with the Early Intervention Partnership Program (EIPP) a maternal home visiting program that connects with women during the prenatal period up through one year postpartum. The participating EIPPs provide additional home visits and support group services to women in their program who identified as either at risk or experiencing perinatal depression.
- Evaluation of the support groups determined that support group services were effective in reducing factors that contribute to perinatal depression; 1) reduction of social isolation; 2) increased parenting skills/confidence; 3) increased community/social supports; and 4) increase knowledge of self-care/stress reduction.

### **Strategy Two: Screening In Multiple Settings**

The Project encouraged and promoted statewide providers to screen in multiple settings for perinatal depression, specifically in the obstetric, family medicine and pediatric settings, as well as home-based screening. Members of the MIMHP Advisory Committee are actively promoting some of these practices. Here are three examples:

#### **Home-Based Screening:**

- **Early Intervention Partnership Program (EIPP):** EIPP conducts a Comprehensive Health Assessment (CHA) with each new participant upon entry. This health assessment includes 14

key health areas, one of which is an emotional health screen. If the participant screen indicates that she might be at risk for or experiencing depression the provider will then perform a depression screen. Screening early is an essential element of the EIPP preventative standard of care for many women feel reluctant to discuss their feelings or are unaware that they may be experiencing depression.

- ✓ At intake: 42% (868/2062) EIPP Participants reported a history of depression including post partum depression.
- ✓ At the initial visit, when the CHA is conducted, 57% (1174/2062) were assessed to have a positive emotional health screen of 1 or higher with a history of mental health concerns.

### **Pediatric Screening:**

- **Dr. Howard King**, pediatrician & founder of the Children's Emotional Healthlink (CEHL). For more information: [www.cehl.org](http://www.cehl.org)
- **Dr. Emily Feinberg** founder of Project E-SMART at the Boston University School of Public Health. For more information: <http://sph.bu.edu/Maternal-a-Child-Health/Project-E-SMART.html>

Feinberg, E et. al. *Improving Women's Health During Internatal Periods: Developing an Evidenced-Based Approach to Addressing Maternal Depression in Pediatric Settings*. Journal of Women's Health Jul 2006, Vol. 15, No. 6: 692-703.

### ▪ **Strategy Three: Collaborative Reimbursement Partnerships**

- In early 2007, the MDPH approached the Massachusetts Medicaid managed care organizations with a collaborative financial proposal that sought to partner EIPP with the existing medical network of care provided by the managed care organizations.

Beginning in early 2008, Network Health and Neighborhood Health Plan are voluntarily entering into financial contracts with the EIPP vendors for the provision of EIPP services to their respective members. Medicaid managed care organizations reimburse the EIPP vendors for home visiting services by a MCH nurse or a social worker utilizing a prior authorization mechanism. Through this collaboration, the MDPH and the Medicaid managed care organizations are able to complement their respective services, enhance managed care organization member benefits, and improve the health and well-being of pregnant and post partum women and their infants.

### ▪ **Strategy Four: Statewide Conferences/Trainings**

- The MIMH Project held a statewide summit in 2006 with experts from around the state to assess the problem in MA and make recommendations for service improvement. The following were top priorities for MA in order to adjust the system to better address perinatal depression:
  - ✓ Screen for perinatal depression in multiple settings and provide reimbursement for screens
  - ✓ Provide advanced trainings for providers around the state on maternal and infant mental health and the dyadic relationship

- ✓ Increase non-clinical services and clinical capacity for women identified with perinatal depression (waiting lists for traditional clinical services, particularly for at-risk women, can be up to four months)
  - ✓ Focus on family-oriented services (merge the maternal and infant worlds)
  - ✓ Provide statewide public awareness on depression and its effects on the family
- The MIMH Project has already, as previously mentioned addressed some of these concerns. Trainings/Conferences have been provided across the state educating providers on maternal and infant mental health issues. More intensive trainings have also been provided on the mother-infant relationship/attachment (the dyadic relationship).
  - **Strategy Five: Public Awareness**
  - The Project has developed and tested a multi-lingual low-literacy public awareness campaign geared at raising awareness around depression and parental stress. The catch phrase is “Being a mother is a hard job” and the brochure lists signs and symptoms of depression and action steps on how to relieve stress. Also a multi-lingual 24/7 Parental Stress Hotline number is provided for parents who need help, resources, or referrals. These materials were made available to all birth hospitals and other targeted agencies across the state. A limited supply is available through the Mass Health Promotion Clearinghouse.

#### **4. SUCCESSFUL STRATEGIES IN OTHER STATES/AGENCIES**

- **Illinois:** The University of Illinois-Chicago Perinatal Mental Health Project successfully collaborated with the state Medicaid system to provide reimbursement for perinatal depression screens, which they have entitled "risk assessments" for pregnant women. Reimbursement is available to all physicians who treat pregnant and postpartum women.
- **New Jersey:** In April 2006 NJ Governor John Corzine signed the PostPartum Depression Screening Bill. This new law requires all health care professionals providing prenatal care to educate women and their families about postpartum depression and it requires health care professionals providing postnatal care to screen new mothers for postpartum depression.
- **Texas:** The Texas Legislature passed HB 341, Parenting and Postpartum Counseling Information, in the 78th Regular Legislative Session (2003). This law requires physicians, midwives, hospitals and birthing centers that provide prenatal care to pregnant women during gestation or at delivery to provide the woman with a current resource list.
- **US Navy:** The Universal Primary Care Perinatal Depression Screening program has been officially made the standard of care throughout the entire U.S. Navy. The protocol uses the Edinburgh Postpartum Depression Scale twice during pregnancy as part of OB prenatal care, and four times postpartum. Three of the postpartum visits are part of well baby clinic follow ups on the Pediatric Service and one is at the six week OB postpartum visit.
- **Maryland:** The Mental Health Association of the Maryland Eastern Shore (HMAMDES) is developing an area-wide universal depression screening and treatment program. MHAMDES formed a coalition of over 13 different organizations and has collaborated with Family Mental Health Institute (FMHI) to provide trainings in the area around the need for screening in multiple settings.<sup>6</sup>

## **5. RECOMMENDATIONS FROM THE MIMHP ADVISORY COMMITTEE**

### **1. Increase perinatal depression screening in multiple settings for early detection and referral.**

Screening should be integrated into provision of care during the prenatal period, at the postpartum visit and during pediatric visits or other maternal primary care visits during the 12 months following the birth. It is important for the screening to be available at multiple sites and through multiple providers including OB/GYN, family medicine, home-visiting services, and pediatrics. Reimbursement for screening should be included as a covered service within public and private insurance coverage. Screening early and often is the most effective way to identify and treat postpartum depression.

Example: Illinois strategy & US Navy strategy

### **2. Increase capacity to provide alternative modes of treatment such as support groups and home-based services.**

Alternative modes of treatment such as support groups are effective in decreasing social isolation, increasing social networks, increasing parenting and self esteem and encouraging mother-infant relationship development, bonding, and attachment. Reimbursement mechanisms should be developed to support these alternative modes of treatment.

Example: Early Intervention Partnership Program support groups

### **3. Collaborative agreements across agencies.**

Partnerships across agencies, as well as collaborations with reimbursement agencies, can create continuity in care and effectively treat the family unit. Reimbursement collaborations between Medicaid and providers, as in the Illinois strategy and the EIPP strategy, demonstrate this system.

Example: Illinois Strategy, US Navy strategy, EIPP & MCO strategy, and MA Childhood Behavioral Health Initiative (mandatory screening at well child visits).

### **4. Increase provider capacity to work with the mother-infant dyad.**

Trainings need to be provided across the state to: 1) increase providers' skills and 2) train new providers around the early dyadic relationship and effective attachment strategies and interventions that can be implemented in front-line practice. Reimbursement mechanisms should be developed to support these trainings.

Example: Maternal and Infant Mental Health Project, United Way Connected Beginnings Program, Jewish Family & Child Service Infant-Parent Training Institute, Infant-Parent Mental Health Post-Graduate Certificate Program (Ed Tronick).

### **5. Culturally sensitive public awareness & education.**

Providing linguistically and literacy-sensitive information on perinatal depression is imperative for new parents. Public awareness materials help break down stigma, provide information and education, and connect parents to resources in their communities.

Example: Maternal and Infant Mental Health Project, New Jersey Strategy, and Illinois Strategy

## RESOURCES

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<sup>1</sup> University of Illinois Chicago Perinatal Mental Health Project

[http://www.psych.uic.edu/index.php?option=com\\_content&view=article&id=110&Itemid=193](http://www.psych.uic.edu/index.php?option=com_content&view=article&id=110&Itemid=193)

<sup>2</sup> Onunaku N. *Improving Maternal and Infant Mental Health: Focus on Maternal Depression*. Los Angeles, CA: National Center for Infant and Early Childhood Health Policy at UCLA; 2005.

<sup>3</sup> *ibid*

<sup>4</sup> Nonacs, Ruta. *A Deeper Shade of Blue: A Woman's Guide to Recognizing and Treating Depression in Her Childbearing Years*.

<sup>5</sup> Center for Disease Control (CDC). *Pregnancy Risk Assessment Monitoring System (PRAMS) and Postpartum Depression*. In: Department of Health and Human Services, Massachusetts Department of Public Health; 2007.

<sup>6</sup> APHA Spring Newsletter

### Additional Resources

Dearing, E., Taylor, B. A. & McCartney, K. (2004). Implications of family income dynamics for women's depressive symptoms during the first 3 years after childbirth. *American Journal of Public Health*. 94:8, 1372-1377.

Gaynes, B.N., Gavin, N., Meltzer-Brody, S., Lohr, K. N., Swinson, T., Gartlehner, G., Brody, S. & Miller, W. C. (2005). *Perinatal depression: prevalence, screening accuracy, and screening outcomes*. Summary, Evidence Report/Technology Assessment No. 119. AHRQ Publication No. 05-E006-1. Rockville, MD: Agency for Healthcare Research and Quality.

Karl, D. J., Beal, J. A., O'Hare, C. M. & Rissmiller, P. N. (2006). Reconceptualizing the nurse's role in the newborn period as the 'Attacher.'" *American Journal of Maternal/Child Nursing*. 31:4, 257-262.

McLearn, K. T., Minkovitz, C. S., Strobino, D. M., Marks, E. & Hou, W. (2006). Maternal depressive symptoms at 2 to 4 months post partum and early parenting practices. *Archives of Pediatrics & Adolescent Medicine*. 160:3, 279-284.

Speilman, E. (2002). Early connections: Mother-Infant psychotherapy in support of perinatal mental health. *Zero to Three*. 26-30.

Zeanah, P. D., Stafford, B. S., Nagle, G. A. & Rice, T. (2005). *Addressing social-emotional development and infant mental health in early childhood systems*. Los Angeles, CA: National Center for Infant and Early Childhood Health Policy. Building State Early Childhood Comprehensive System Series.